Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services

Case Management for Persons with MH/DD/SA

October 14, 2009

Legislation

- **Section 10.68A (a) (10) states that:** *The Department of Health and Human Services shall develop a plan for the consolidation of case management services. The plan shall address the timeline and process for implementation, the vendors involved, the identification of savings, and the Medicaid recipients affected by the consolidation. Consolidation under this subdivision does not apply to HIV case management. By December 1, 2009, the Department shall report on the plan to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division.*

The Process

- A public forum was held – over 300 people attended.
- A work group was formed consisting of providers, family/recipients, other DHHS divisions, local Health Depts., local DSSs, LMEs and other interested parties.
- Agendas and call-in number was posted on the DMA website. Minutes and handouts were posted to the website.
- The group examined definitions, functions, administrative rules, documentation, qualifications of staff and providers, rates and impact on indigent care and other service delivery
- The draft proposals were distributed and posted. Final meeting is scheduled to discuss feedback received and next steps

Goals and Outcomes

Recipient Goals/Outcomes

- The recipient must be the center of our care instead of having case management done on a program specific basis.
- The recipient will have timely and uncomplicated access to care via “no wrong door” policy.

Goals and Outcomes cont'd

Case Manager Goals/Outcomes

- Increase quality and continuity of care of recipients through effective and efficient case management including simplifying and eliminating ineffective administrative processes where allowed by regulations.
- Implement client specific outcomes which address all identified needs.
- Decrease 'silo' case management
- Maintain disability/need specific expertise of the case manager.
- Case managers shall receive training to promote the highest quality possible and to insure the prevention of substandard service delivery.
- Develop professional standards for case managers.

Goals and Outcomes cont'd

System Goals/Outcomes

- Simplify the maze of the various types of case management services and systems for families and recipients.
- Eliminate duplication of functions and increase coordination/integration across case management functions to eliminate unnecessary use of Medicaid and other publicly funded services.
- Reduce costs or potential cost increases in the various covered benefit categories of Medicaid
- Support the development of interoperable medical record systems that support collaboration across the continuum of care.
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Purpose for Consolidating CM

- Increase quality and continuity of care
- Person centered
- Eliminate duplication
- Decrease ‘silo’ case management
- Reduce costs as a result of better coordination and quality care

Case Management

- Services that assist individuals in gaining access to needed medical, social, educational, and other services.
- Consists of 4 federally defined functions:
  - assessment,
  - development of care plan,
  - referral, and
  - monitoring and follow-up
- Optional Medicaid service
- CAP waivers require case management services

Care Management

- Addresses programmatic and preventive services needs of population
- Outcome-focused
- Uses data to monitor population and service delivery
- Uses systems, incentives, and information to improve care and manage medical/social/ behavioral health conditions more effectively

Expenditures in SFY 2009 (CM in Enhanced MH/SA and Community Support are estimates)

Summary of Case Management and Related Services, Dates of Service in SFY 2009

	SFY 2009							
							Amount Paid for Case Management	
Program	Distinct Recipients	Distinct Recipients in CCNC[4]	CCNC Percent	Paid	Units	Estimated Total Cost of CM	Federal 64.46%	State & Local 35.54%
CAP/C CM (per 15 min)	765	438	57.3%	$ 1,418,611	95,223		$ 914,437	$ 504,174
CAP/C CM (per month)	230	76	33.0%	$ 657,000	1,752		$ 423,502	$ 233,498
CAP/DA Case Mgmt	13,278	2,764	20.8%	$ 24,705,273	1,691,109		$ 15,925,019	$ 8,780,254
CAP/Choice Care Adv	63	27	42.9%	$ 129,649	8,503		$ 83,572	$ 46,077
CAP/MRDD Waiver TCM	10,137	5,580	55.0%	$ 38,686,410	1,875,280		$ 24,937,260	$ 13,749,150
DD Targeted CM	8,960	4,881	54.5%	$ 24,401,164	1,188,048		$ 15,728,990	$ 8,672,174
At Risk Case Mgmt[1]	5,008	2,099	41.9%	$ 3,445,246	357,006		$ 3,445,246	
HIV Case Mgmt	2,485	1,429	57.5%	$ 5,449,188	396,244		$ 3,512,547	$ 1,936,641
Child Svcs Coord	18,633	16,292	87.4%	$ 9,560,371	440,057		$ 6,162,615	$ 3,397,756
Maternal Care Coord	28,690	10,538	36.7%	$ 13,171,818	450,770		$ 8,490,554	$ 4,681,264
MaternalOutreachWrkr	2,662	1,779	66.8%	$ 1,157,236	70,498		$ 745,954	$ 411,282
Early Intervention	14,852	11,886	80.0%	$ 13,693,170	468,221		$ 8,826,617	$ 4,866,553
Health Check Coord	933,208	816,307	87.5%	$ 2,871,750	8,274,961		$ 1,851,130	$ 1,020,620
Total				**$ 139,346,886**	**15,317,672**		**$ 91,047,443**	**$ 48,299,443**
	Bundled Service Programs							
SubAbuseIntervOutpat	1,190	798	67.1%	$ 2,591,956	17,999	$ 994,985	$ 641,367	$ 353,618
Assertive Comm Tx Tm	2,762	1,137	41.2%	$ 30,422,785	94,074	$ 1,616,024	$ 1,041,689	$ 574,335
Comm Support Team	5,564	3,053	54.9%	$ 100,282,481	5,862,194	$ 3,209,897	$ 2,069,099	$ 1,140,797
Intensive InHome Svcs	4,152	3,349	80.7%	$ 46,226,294	179,522	$ 2,338,225	$ 1,507,220	$ 831,005
Multi-Systemic Therapy	508	406	79.9%	$ 4,956,193	132,850	$ 312,113	$ 201,188	$ 110,925
SA CompOutpat Tx	504	370	73.4%	$ 3,409,031	69,224	$ 1,530,543	$ 986,588	$ 543,955
Total				**$ 187,888,740**	**6,355,863**	**$ 10,001,786**	**$ 6,447,151**	**$ 3,554,635**
	Community Support Programs							
CommSupp-Child	43,248	34,576	79.9%	$ 294,624,481	21,151,258	$ 24,930,145	$ 16,069,971	$ 8,860,174
CommSupp-Adult	22,099	12,174	55.1%	$ 121,578,635	8,725,657	$ 12,699,174	$ 8,185,888	$ 4,513,286
CommSupp-Gp	582	431	74.1%	$ 246,244	56,368	$ 7,882	$ 5,081	$ 2,801
Total				**$ 416,449,360**	**29,933,283**	**$ 37,637,201**	**$ 24,260,940**	**$ 13,376,261**

DRIVE data were queried October 12, 2009 for Dates of Service July 1, 2008 to June 30, 2009 (SFY 2009)
Query criteria for each program/service are given in Table 2.
CCNA counts were run on 07/21/2009 using criteria specified by CCNC

Providers

- CAP-MRDD – Private agencies endorsed by LME
- CAP-DA – case management provided by lead agency. Can be DSS, hospital, home health or senior program
- CAP-C – case management provided by local county agencies such as DSS, hospital, home health, or case management agency
- Case Management agencies providing case management to people with DD
- Local public health depts. and other agencies who provide other types of case management such as Maternal Care, Child Service Coordination, EI, etc.

- ICF-MR facilities are not effected because case management is part of the per diem. It is part of the social worker function and may not be billed separately.

General vs Specialized CM

- The definition of case management is the same across program types
  - As the program silos are eliminated and administrative functions reduced, staff qualifications can be “general”
  - Acuity of the recipient may require “specialized” CM or more highly trained
  - Qualifications will be based upon the required expertise of recipient acuity, not based upon disability, condition or provider type
  - Differentiate rate based upon the qualifications not on provider type
- Access will be based upon the clinical policy criteria

Short Term Plan

- Limit Number of Units and clarify the entrance, continued stay and discharge criteria
- Increase Administrative Efficiencies: Examples:
  - *Allow direct billing for CAP DME waiver supplies*
  - *Consolidate and reduce forms*
  - *Align CAP waiver policies*
- Modify rate structure
  - *Standardize rates among programs*
  - Move to a case rate structure instead of current method of billing in 15 minute units

Short Term Plan

- Eliminate duplication
  - *Place audit in system to not allow billing by more than one CM provider in the same month*
  - *Examples: CAP-MR/DD with Community Support, HIV CM with Community Support, MST with Community Support, Maternal Care with Community Support*
- Develop linkages to CCNC networks and Primary Care Physician
- Reduce or eliminate prior authorization on targeted case management, when appropriate
- Coordinate with CS workgroup and make changes as needed
- ***Residual effect of consolidating case management will be a reduction of other health care/Medicaid services through better coordination***

Projected Savings

Recommended Change	Projected State Savings 2010
Establish Unit Limits or modifying criteria (effective 11/1/09) *finalizing limits*	$10 -13,000,000
Eliminate Duplication (effective 11/1/09)	$ 2,500,000
Eliminate Prior Approval on CAP-MRDD	$ 1,400,000
Consolidate Health Check into CCNC (effective 11/1/09)	$ 280,000
TOTAL	$14 -17,180,000

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CASE MANAGEMENT SERVICES

DMA
- Finance
- Rate Setting
- Clinical Oversight
- Clinical Policy

PMPM

PMPM

Managed Care Capitated Rate

MEDICAL HOME
PCP & OBGYN

Every Medicaid recipient will have a medical home.

FFS

CCNC pays PMPM

NC CCN Inc.
- Practice Coordination
- Clinical Policy
- Quality Assurance
- Outcomes Metrics

CCNC Pays PMPM

Local CCNC Networks
- Health Check
- Case Management
- Care Management
- Data Transfer & Mgmt
- Quality Assurance
- Outcome Metrics
- 1st Level Program Integrity

FFS

Local PH Depts.
- High Risk OB
- Quality Assurance
- Outcome Metrics
- CSHN
- EI

LMEs
- STR
- Endorsements
- Care Coordination
- Monitoring
- Quality Assurance
- Outcome Metrics
- Program Integrity

CAP MRDD
Including CM

Comprehensive MH Providers
Includes CM

DD CM

No DMA $$

At Risk CM
- Data Transfer
- Clinical Coordination
- Quality Metrics

FFS

FFS

FFS

CAP/C CM
- Data Transfer
- Clinical Coordination
- Quality Metrics

HIV CM
- Data Transfer
- Clinical Coordination
- Quality Metrics

CAP/DA CM
- Data Transfer
- Clinical Coordination
- Quality Metrics

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CCNC's Role

- Identify high risk factors with TCM agencies and ensure clinical coordination
- Develop patient risk profiles for entities such as LMEs who are charged with care management activities for an assigned population
- Expand key medical information to be provided for all Medicaid patients at point of care to prevent service duplication and optimize coordination of care
- Expand role of privacy officers and deploy network staff facilitate appropriate data transfer and clinical coordination with private case management agencies on a patient by patient basis
- Care Management functions to Health Check enrollees
- Per Member/Per Month will be increased for CCNC to provide for infrastructure enhancements

Future Plans

- Develop Service Definition
- Revise and submit State Plan Amendments (SPAs) to CMS
- Define outcome metrics for each area of CM
- Define risk factors that indicate CM (general and specific) needed for each area
- Submit CAP waiver revisions to make program policies more consistent

Future Plans cont'd

- Modify business processes and roles as a result of changes
- Develop data sharing processes and agreements
- Revise payment structure
- Determine implementation strategy and plan
- Develop Time Line for implementation
- Develop transition plan for current recipients and providers
- Develop Training plan

Coordination with Community Support Work Group

- Case Management definition is being submitted to CMS
- Comprehensive MH providers will be responsible for providing case management as a part of their services.
- DD Case Management will remain as stand alone agency and not be a comprehensive provider.